Fairmont Dental Group
Dr. Andrew Cheng & Associates
Suite 515 — 750 West Broadway
Vancouver, BC V5Z 1H4
Phone: (604) 709-9001
Website: http://www.dentistsinvancouver.org
E-mail: info@dentistsinvancouver.org

Personal Information (All information is strictly confidential)

Last Name: ______________________________ First Name: ______________________________

Date of Birth: (Month/Day/Year) ____

M: ❑ F: ❑ Marital Status: Married ❑ Single ❑ Divorced ❑ Other ❑

Address:____

City: ___________________ Province: ________________ Postal Code: _______________

Phone: Home ______________________________
Work ______________________________ E-Mail Address: _________________________
Cell ______________________________

Emergency Contact: ____

Emergency Contact Phone Number: ( ) ____

Family Physician: _______________________ Phone: ( ) ______________________

Referred by: ____

Account will be paid by: Dental Insurance ❑ Cash/Credit Card or Cheque ❑

Dental Insurance Information

Name of Insurance Company: ____

Name of Employer: ____

Group/Policy Number: ____________________ Cert/ID Number: __________________________

Coverage: A. Basic: ❑ B. Major: ❑

Financial Limit: ____

Please note: We will bill most dental plans directly on behalf of the patient. Please be advised this is for your convenience only, we are not liable or responsible for any portion not covered by your dental plan.

I, the undersigned, authorize dental treatment to be rendered by the dentist and him/her staff, and assume full financial responsibility at the end of each dental appointment regardless of insurance or any other third party involvement.

Signature of Patient: ____

Patient Medical History

Preferred Name: ____________________ Medical Alert: ____________________

Have you been under the care of a medical doctor during the past two years? Yes ❑ No ❑
If Yes, for what? ____________________
Physician's Name: ____________________ Phone: ____________________
Address: ____________________ City: ____________________
Province: ____________________ PC: ____________________

Have you taken any medication or drugs during the past two years? Yes ❑ No ❑

Are you taking any medication, drug or pills now, including regular dosages of aspirin? Yes ❑ No ❑

Have you ever taken prescription medications for weight loss? (e.g. Fen-Phen) Yes ❑ No ❑

If yes to any of the above, did you have a medical exam for heart issues? Yes ❑ No ❑

Have you ever taken prescription medications for osteoporosis prevention? Yes ❑ No ❑
If yes, did you take any Fosamax or Aredia (Bisphosphonate)? Yes ❑ No ❑
Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes ❑ No ❑
If yes, please list: ____________________
Have you been a patient in the hospital during the past five years? Yes ❑ No ❑

Indicate which of the following you have had, or have at present. Check "yes" or "no" for each item.

Heart (Surgery/Disease/Attack)	Yes ❑	No ❑	Ulcers	Yes ❑	No ❑
Hepatitis A (infectious)	Yes ❑	No ❑	Chest Pain	Yes ❑	No ❑
Hepatitis B (serum)	Yes ❑	No ❑			
Diabetes	Yes ❑	No ❑	Venereal Disease	Yes ❑	No ❑
Congenital Heart Disease	Yes ❑	No ❑	Thyroid Problem	Yes ❑	No ❑
A.I.D.S	Yes ❑	No ❑	Heart Murmur	Yes ❑	No ❑
Glaucoma	Yes ❑	No ❑	H.I.V. Positive	Yes ❑	No ❑
High Blood Pressure	Yes ❑	No ❑	Contact Lenses	Yes ❑	No ❑
Cold Sores/Fever Blisters	Yes ❑	No ❑	Mitral Valve Prolapse	Yes ❑	No ❑
Emphysema	Yes ❑	No ❑	Blood Transfusion	Yes ❑	No ❑
Artificial Heart Valve	Yes ❑	No ❑	Chronic Cough	Yes ❑	No ❑
Hemophilia	Yes ❑	No ❑	Heart Pacemaker	Yes ❑	No ❑
Tuberculosis	Yes ❑	No ❑	Sickle Cell Disease	Yes ❑	No ❑
Rheumatic Fever	Yes ❑	No ❑	Asthma	Yes ❑	No ❑
Bruise Easily	Yes ❑	No ❑	Arthritis/Rheumatism	Yes ❑	No ❑
Hay Fever	Yes ❑	No ❑	Liver Disease	Yes ❑	No ❑
Cortisone Medicine	Yes ❑	No ❑	Latex Sensitivity	Yes ❑	No ❑

Yellow Jaundice	Yes ❑ No ❑	Swollen Ankles	Yes ❑ No ❑
Allergies or Hives	Yes ❑ No ❑	Neurological Disorders	Yes ❑ No ❑
Stroke	Yes ❑ No ❑	Sinus Trouble	Yes ❑ No ❑
Epilepsy or Seizures	Yes ❑ No ❑	Diet (Special Restricted)	Yes ❑ No ❑
Radiation Therapy	Yes ❑ No ❑	Fainting or Dizzy Spells	Yes ❑ No ❑
Artificial Joints (hip, knee, etc)	Yes ❑ No ❑	Chemotherapy	Yes ❑ No ❑
Nervous/Anxious	Yes ❑ No ❑	Kidney Trouble	Yes ❑ No ❑
Tumors	Yes ❑ No ❑	Psychiatric/Psychological Care	Yes ❑ No ❑

Have you lost or gained more than 10 pounds in the past year? Yes ❑ No ❑

Do you have or have you had any disease, condition or problem not listed? Yes ❑ No ❑

Women:
Taking birth control pills? Yes ❑ No ❑
Are you: Pregnant? Yes ❑ No ❑ Months _____ Nursing Yes ❑ No ❑

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the doctor of change in my health or medication.

Signature of Patient/Guardian: ___________________________ Date: ___________________________

Dentist Signature: ___________________________ Date: ___________________________